Certification Board for Alcohol and Drug Professionals (CBADP)
3101 West 41st Street, Suite 205, Sioux Falls, SD 57105
Phone: 605-332-2645 Fax: 605-332-6778
Email: cbadp@midconetwork.com Web: www.dhs.sd.gov/brd/CBADP

APPLICATION FOR COUNSELOR CERTIFICATION

Attached please find the Application for Counselor Certification. Please complete the application in its entirety. Do not leave information blank or attach separate sheets indicating 'see attached'. Application deadlines are January 1 and July 1 of every year. Applications can be submitted at anytime prior to the deadline. All requirements must be completed at the time of application for certification. Waivers will not be granted to later complete courses or work experience requirements. Applications will be denied if there are any incomplete items in the application portfolio.

Your supervisor(s) must complete the 'Chemical Dependency Counselor Evaluation by Supervisor' form and send it directly to the Certification Board for Alcohol and Drug Professionals (CBADP). Also, please mail or give the 'Professional Recommendation' form to three professional colleagues and have them send it directly to the CBADP. If you have completed work experience at more than one agency, make a copy of the 'Work Experience Verification' form and send it to each agency for verification of all your work experience hours. The completed application must be submitted by the application deadline for inclusion in the next applicable testing cycle.

Upon receipt of your application portfolio, it will be reviewed for acceptance. If the portfolio is not complete, you will be notified of any missing items. When the application portfolio is complete, notification will be provided for the scheduling of the written examination. Written exams are administered the second Friday of March and the second Friday of September. The CBADP sends official written notification of the test results within 30 days of the testing date. Please note that policy prohibits the CBADP from releasing test results over the telephone.

Upon successful completion of the portfolio review and passing the written examination, the applicant will be issued a certificate. In order to maintain your certification status, you must comply with all requirements for yearly recertification.

Failure to meet the requirements for certification, or failure of the examination, will result in the inability to achieve certification. Insufficient experience or course work will require the applicant to reapply for certification. Applicants failing the written examination will be required to submit the retesting fee and a letter of intent to retest in the next immediate testing cycle.

The CBADP is required to comply with SDCL 25-7A-56 which is a prohibition against issuance of professional license, registration, certification, or permit of application in the event of child support arrearage. Applicants listed on the State Registry will not be granted Trainee Recognition, Certification or Recertification until arrangements have been made with the Department of Social Services, Office of Child Support Enforcement and the individual's name is cleared via monthly written reports from that office.

The CBADP will make special testing accommodations for individuals meeting the American with Disabilities Act (ADA) guidelines. Applicants must complete the form included in the application packet outlining the disability, the accommodations requested, and provide a written statement from a licensed physician, psychiatrist, or psychologist regarding the disability. All decisions for special accommodations are made in consultation with the testing company.

If you have any questions concerning the application or the testing process, please contact the CBADP Administrative Office.

SEND COMPLETED APPLICATION, TRANSCRIPT(S), AND FEE TO:

CBADP
3101 West 41st Street, Suite 205
Sioux Falls, SD 57105

"Getting Ready to Test" Publications Order Form

The Distance Learning Center, LLC, is pleased to offer addiction counselor credentialing test candidates the following publications to help them study and pass the written examination. Use this form when placing orders by fax or by mail. Directions are found at the end of the order sheet. Information about the publications can be found on the website: www.readytotest.com. You can also order on-line.

Step 1 -- Select the "Getting Ready to Test" materials you wish to purchase

_____ ***Item #W401*** ***The Written Examination***
Cost: $52 plus $8 shipping/handling (Priority Mail) - $60 total

_____ ***Item #M404*** ***A Review & Preparation Manual for Drug and Alcohol Credentialing Examinations***

[ ] Cost: $149 plus $12 shipping/handling (FedEx Ground Shipment 3-5 Days) - $161 total

[ ] Cost: $149 plus $15 shipping/handling (USPS Priority Shipment 2-3 Days) - $164 total

Step 2 -- Personal and Payment Information - *Be sure to enter all information requested.*

PLEASE PRINT

Complete Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Daytime Phone Number: _____

Payment method: Check___ Money Order___

Credit Card: [ ] VISA [ ] American Express [ ] Discover [ ] MasterCard

Card Number: _____

Expiration Date: _____ / _____
(month) (year)

Order Total: _____

Step 3 -- Mail this form with payment (check, money order, credit card information) to:
Vic Shaw, DLC LLC
PO Box 29195
Santa Fe, NM 87592

Or fax this form with credit card information to: (801) 991-7081

Application for Certification

A $250.00 check or money order must accompany this application.
Submit to: CBADP, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105

I AM APPLYING FOR: ____ CCDC Level I ____ CCDC Level II ____CCDC Level III

CERTIFICATION TRACK: ____ Academic Track ____ Experience Track

PERSONAL DATA:

Name: _____
First Middle Last Maiden

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Work Fax: _____

Email: _____

Social Security #: _____ Birth date: _____

CURRENT EMPLOYMENT:

YOU ARE REQURED TO SUBMIT A COPY OF YOUR CURRENT JOB DESCRIPTION

Agency Name: _____

Agency Mailing Address: _____

City: _____ State: _____ Zip: _____

Job Title: _____

Name of CCDC Supervisor: _____

STATISTICAL INFORMATION: (This information is used for statistical purposes only.)

Gender:
_____Female
_____Male

Ethnicity:
_____African American
_____American Indian
_____Asian/Pacific Islander
_____Caucasian
_____Hispanic/Latino
_____Other: _____

Educational/Academic Data

Official transcripts must be submitted for all education. If you have a college degree, you do not have to submit your high school transcripts.

High School Attended: _____

Date of Graduation: _____

GED: _____Date: _____

Where Issued: _____

COLLEGE/UNIVERSITY:

Name	Location	Enrolled From	Enrolled To	Degree(s) Earned

SPECIALIZED EDUCATION DOCUMENTATION:

List all completed specialized educational courses. All courses must equal 3 or more semester credits and earn a "C" grade or higher.

Requirement	Name of College or University	Prefix - Course Number	Name of Course	Credit Hours	Term Taken	Grade
Example	FSU	HS 212	Study of Alcohol	3	Fall '95	B
Intro to Alcohol Use and Abuse						
Intro to Drug Use and Abuse						
Foundations of Individual Counseling						
Alcohol & Drug Group Counseling						
Alcohol & Drug Treatment Continuum						
Professional Ethics for the CD Counselor						
Counseling Families with Alcohol or Other Drug Issues						
Cultural Competency **OR**						
Special Populations						
CD-Specific Elective						

Work Experience Documentation

All experience must be specific to chemical dependency counseling. List all relevant experience, beginning with your current place of employment. Verification must be received for all experience.

Applicant's Name: ____

Agency Name: ____

Address: ____

City: ______________________ State: ________ Zip: ______________

Phone: ______________________ Supervisor: ______________________

Job Title: ____

Dates of Employment: From ______________________ To ______________________

Was the experience Full Time: ____________ Part Time: ____________ Volunteer: ____________

Agency Name: ____

Address: ____

City: ______________________ State: ________ Zip: ______________

Phone: ______________________ Supervisor: ______________________

Job Title: ____

Dates of Employment: From ______________________ To ______________________

Was the experience Full Time: ____________ Part Time: ____________ Volunteer: ____________

Agency Name: ____

Address: ____

City: ______________________ State: ________ Zip: ______________

Phone: ______________________ Supervisor: ______________________

Job Title: ____

Dates of Employment: From ______________________ To ______________________

Was the experience Full Time: ____________ Part Time: ____________ Volunteer: ____________

(Duplicate page, if necessary)

Work Experience Verification

All experience must be verified. Applicant is to complete the top section of this form; make copies and send the form to all agencies, employers, internship sites, etc. The bottom section is to be completed by the agency, employer, internship site, etc.

The applicant listed below is applying for certification as a chemical dependency counselor. Please verify the work experience for this individual and return this form directly to the Certification Board for Alcohol and Drug Professionals, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105. If the information is not correct, please make changes, initial and mail with a copy of the person's written job description.

Applicant's Name: _____

Address: _____

City: _____State: _____ Zip: _____

Job Title: _____

Dates of Employment: From _____ To _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

STOP HERE

THE FOLLOWING MUST BE COMPLETED BY THE AGENCY, EMPLOYER, INTERNSHIP SITE, ETC.

I hereby attest that the above information is true and correct. This person was involved in the supervised counseling of diagnosed alcohol and drug abuse clients with the majority of their time spent in individual, group and/or family counseling; and, the remaining experience was related to the AODA Counselor Core Functions.

Signature: _____

Name: _____

Name of Agency: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Title: _____

Date: _____

Total **number of hours** of qualifying work experience: _____

Supervised Practical Training Hours

Provide a description of your 300 hours of supervised practical training. You must have at least 10 hours in each area and give specific examples of how you apply the principles in your professional practice.

Applicant's Name: _____

Supervisor's Name: _____

Agency where completed: _____

SCREENING	**TOTAL HOURS:**

Description:

INTAKE	**TOTAL HOURS:**

Description:

ORIENTATION:	**TOTAL HOURS:**

Description:

ASSESSMENT	**TOTAL HOURS:**

Description:

Supervised Practical Training Hours (Continued)

TREATMENT PLANNING	**TOTAL HOURS:**

Description:

COUNSELING	**TOTAL HOURS:**

Description:

CASE MANAGEMENT	**TOTAL HOURS:**

Description:

CRISIS INTERVENTION	**TOTAL HOURS:**

Description:

CLIENT EDUCATION	**TOTAL HOURS**:

Description:

Supervised Practical Training Hours (Continued)

REFERRAL	**TOTAL HOURS:**

Description:

REPORTS & RECORD KEEPING	**TOTAL HOURS:**

Description:

CONSULTATION	**TOTAL HOURS:**

Description:

I hereby certify that all of the above information is, to the best of my knowledge, true.

_____ _____

Signature of Supervisor Date

Professional Code of Ethics

The Professional Code of Ethics applies equally to all Certified Chemical Dependency Counselors, Certified Prevention Specialists, Trainees, Interns, and individuals in the process of applying for certification. The Certification Board for Alcohol and Drug Professionals (CBADP) believes that all people have rights and responsibilities through every stage of human development. The goal of the CBADP is for addiction professionals to treat everyone with the dignity, honor, and reverence that is fitting to them.

The Professional Code of Ethical Conduct entitles human beings to the physical, social, psychological, spiritual, and emotional care necessary to meet their individual needs. All Certified Professionals, Trainees, and Interns have a responsibility to adhere to the following guiding principles:

1. That I have a total commitment to provide the highest quality of care for those people who seek my professional services.
2. That I will dedicate myself to the best interests of clients and assist them to help themselves.
3. That at all time, I shall maintain a professional relationship with clients.
4. That I will be willing, when I recognize that it is in the best interest of the client, to release or refer them to another program or professional.
5. That I shall adhere to the laws of confidentiality and professional responsibility of all records, materials, and knowledge concerning clients.
6. That I shall not in any way discriminate against clients or other professionals.
7. That I shall respect the rights and views of other professionals and clients.
8. That I shall maintain respect for institutional policies and management functions within agencies and institutions, but I will take the initiative toward improving such policies if it will best serve the interest of clients.
9. That I have a commitment to assess my own personal strengths, limitations, biases, and effectiveness on a continuing basis; that I shall continuously strive for self-improvement and professional growth through further education and/or training.
10. That I have a responsibility for appropriate behavior in all areas of my professional and private life, and to provide a positive role model especially in regard to the personal use of alcohol and other drugs.
11. That I have a responsibility to myself, my clients, and other associates to maintain my physical and mental health.
12. That I respect the client's right to worship or not, according to their conscience and beliefs, and that I will not impose my own beliefs, values, or standards upon them.
13. That I have a professional responsibility to understand and appreciate different cultures for persons whom are or may be in my care or are recipients of my professional services. I will demonstrate sensitivity to cultural differences in my professional practices.
14. That I have a regard for an individual's needs and rights to equal protection and due process under the laws of the State of South Dakota.

Private conduct is a personal matter, except when such conduct compromises the fulfillment of professional responsibilities or may endanger the health or safety of clients who are or may be under my care. As a professional, I have a responsibility to report, whether obvious or perceived, any ethical violations or concerns related to my peers.

I understand and subscribe to the preceding professional code of ethics and understand that any violation of the principles will be grounds for disciplinary action and sanctions.

☐ **By checking this box, I hereby attest that I have read and will comply with the 2004 Codes of Ethics and Standards of Practice of the Certification Board for Alcohol and Drug Professionals.**

The Codes of Ethics can be viewed and/or printed at: www.dhs.sd.gov/brd/CBADP. Applicants who have not read the Codes of Ethics and have not checked the box above will not be granted certification by the CBADP.

_____ _____

Signature of Applicant Date

Authorizations and Releases

I hereby attest that I have not been convicted of, plead guilty, or no contest, to any felony, or to any crime involving moral turpitude, or like offense within the past five years.

I hereby understand that being convicted of, or pleading guilty, or no contest, before a court in this state or any other state, or before any federal court for any offense punishable as a felony, or like sanction, will be grounds for denial of, or revocation of certification, recertification, or trainee recognition.

I hereby understand that if I have had a felony conviction, and/or pled guilty, or no contest, or received a suspended imposition of sentence, it must have been at least five (5) years prior to the date of application for trainee recognition, student internship status, certification or recertification. I also understand that all sentencing requirements must be completed or satisfied prior to the date of application for any of the above.

I confirm that I have not been denied certification or licensure or had any disciplinary sanctions against me from this or any other certifying or licensing authority in this or any other state. If I have been denied or had disciplinary action, I have notified the Certification Board for Alcohol and Drug Professionals (CBADP) in writing of this action.

I hereby authorize the CBADP to release to any agency, facility, organization, or individual any and all information necessary for verification of credentials.

I hereby authorize any agency, facility, organization, or individual to release any and all information necessary to fully and properly evaluate my application before the CBADP. The CBADP reserves the right to request further information or documentation to evaluate the application and/or professional competence of individuals.

I hereby release and hold harmless the CBADP, its Board of Directors, its officers, its employees, and any agency, facility, organization, or individual from any and all manner of suits, actions, claims, and judgments which might arise from such efforts to further substantiate and document my application.

I hereby understand that the CBADP can deny or revoke certification, trainee recognition, or student internship status on the basis of misrepresentation on my application, or any other application, to include intentionally false or misleading statements or intentional omissions. I understand that I will be barred from applying for certification or recertification for not less than two (2) years if it is proven that I have misrepresented the facts on any aspect of my application, or any other application, for trainee recognition, student internship status, certification or recertification.

I hereby certify that the information contained herein is correct and true, and that I understand the application and these authorizations and releases.

On the line below, please print your name the way you would like it to appear on your certificate:

_____

_____ _____

Signature of Applicant Date

CHEMICAL DEPENDENCY COUNSELOR EVALUATION BY SUPERVISOR

INSTRUCTIONS FOR THE APPLICANT: Give or mail this form directly to your supervisor(s) after you have filled in the bottom portion of this page. If your present supervisor has been supervising you for less than six (6) months, make a copy of this form and provide it to your immediate and past supervisors.

CONFIDENTIAL

Dear Supervisor:

The employee listed below is applying to the Certification Board for Alcohol & Drug Professionals (CBADP) for certification as a Chemical Dependency Counselor. The information requested here is an essential part of the Board's evaluation of the competence of the applicant and must be on file before the application can be processed.

The CBADP believes that your observation will provide a more complete and accurate impression of the knowledge and skills of the applicant than is available from other sources. Your evaluation, plus those received from the professional references and the data furnished by the applicant, will be used in determining eligibility for certification. The process can only be as good as you and the others make it, by careful and truthful reporting.

Please return the completed evaluation DIRECTLY TO:

CBADP
3101 West 41st Street, Suite 205
Sioux Falls, SD 57105

APPLICANT: _____ DATE: _____

SUPERVISOR: _____

TITLE: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____

AGENCY PHONE: _____

CHEMICAL DEPENDENCY COUNSELOR EVALUATION BY SUPERVISOR
(Continued)

APPLICANT'S NAME: _____

The following items represent the skills needed by a Chemical Dependency Counselor. Evaluate the applicant in each area. Mark the rating most descriptive of the counselor's demonstrated skills. **A rating of 1 or 2 will cause the application to be denied**. Use N/O (not observed) ONLY if you have never observed nor have any knowledge of the applicant's skill in that area. Use the following rating scale:

1 – POOR (Not Minimally Acceptable) 2 – NEEDS IMPROVEMENT (Not Minimally Acceptable)
3 – ACCEPATBLE 4 – GOOD 5 – EXCELLENT

COUNSELOR SKILL AREAS	Poor	Excellent	N/O
SCREENING: Determining appropriate and timely services for clients with knowledge of his/her problems and their intensity.	1 2	3 4 5	
CLIENT INTAKE: The process of collecting client information for assessment purposes.	1 2	3 4 5	
CLIENT ORIENTATION: Providing clients with general goals, rules, services, rights, etc. of program services.	1 2	3 4 5	
CLIENT ASSESSMENT: Identification and evaluation of information to determine appropriate treatment services.	1 2	3 4 5	
CHEMICAL DEPENDENCY EVALUATION: Knowledge and application of the major theories and stages of addiction and the symptomatology of chemical dependency for assessment of clients.	1 2	3 4 5	
TREATMENT PLANNING: Defining problems and needs, establishing long- and short-term goals and developing a treatment process and the resources to be used.	1 2	3 4 5	
COUNSELING SKILLS: (Individual, Group, Family) The utilization of special skills to assist in assessing client's problems and facilitating appropriate changes.	1 2	3 4 5	
CASE MANAGEMENT: The coordination of services, agencies, resources or people within a planned framework of action for the achievement of established goals.	1 2	3 4 5	
CRISIS INTERVENTION: Assessing, defining and responding to the needs during acute, emotional, and/or physical distress.	1 2	3 4 5	
CLIENT EDUCATION: Provision of information concerning alcohol and other drug abuse implications, available services, and resources.	1 2	3 4 5	
REFERRAL: Identifying and limiting of appropriate services, familiarization of community and state resources available with demonstration of the referral process, including confidentiality requirements.	1 2	3 4 5	
REPORT AND RECORD KEEPING: Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries, and other client-related data.	1 2	3 4 5	
CONSULTATION: Relating with agency staff and other professionals to assure comprehensive, quality care for clients.	1 2	3 4 5	
PROFESSIONAL & ETHICAL RESPONSIBLITIES: A counselor's ability to adhere to generally accepted ethical and behavioral standards of conduct and continuing professional development.	1 2	3 4 5	

CHEMICAL DEPENDENCY COUNSELOR EVALUATION BY SUPERVISOR (Continued)

Are you involved in the administration/management of the program where you are employed?
_____ No
_____ Yes, limited to clinical aspects (i.e., supervision of counselors).
_____ Yes, limited to administrative responsibilities.
_____ Yes, both _____% clinical and _____ % administrative.

How long have you supervised this applicant? _____

For what period of time, while under your supervision, was chemical dependency counseling the major part of this applicant's responsibilities?

From: _____ To: _____

Describe those activities: _____

_____

Comments and/or additional information you feel may be pertinent: _____

_____

I hereby certify that I have been in a position to observe and have first-hand knowledge of the applicant's work at: _____
(Name of work setting)

_____ I recommend this applicant for certification as a CD counselor.

_____ I have some reservations in recommending this applicant for certification.

_____ I do not recommend this applicant be granted certification..
(Any rating of 1 or 2 on the 'Counselor Skill Areas' from the pervious page, requires a "do not recommend".)

I hereby certify that all of the above information is, to the best of my knowledge, true.

_____ _____
Signature of Supervisor Date

Professional Recommendation Form

Provide this form to a professional and/or academic colleague who is acquainted with your chemical dependency counseling experience. Provide a pre-addressed, stamped envelope so the form can be mailed directly to the CBADP Administrative Office.

NOTE: ANY INDIVIDUAL WHO HAS COMPLETED THE 'EVALUATION BY SUPERVISOR' FORM FOR THIS APPLICANT MAY NOT SUBMIT A 'PROFESSIONAL RECOMMENDATION' FORM.

PART I - TO BE COMPLETED BY THE APPLICANT

Complete the information below. Give this form to a professional who is acquainted with your work performance and abilities. Be sure to provide the individual with a pre-addressed, stamped envelope so the form can be mailed directly to the CBADP.

Name of Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that this recommendation will be used in determining my eligibility for certification and is a character reference. Therefore, I agree and understand that I will not be entitled to this information under any circumstance.

_____ _____

Applicant's signature Date

PART II - TO BE COMPLETED BY A PROFESSIONAL OR ACADEMIC ACQUAINTANCE

The person listed above has applied for certification as an Alcohol and Drug Counselor. The signature above authorizes you to complete this form. Your assessment will assist the Board of Directors in determining the applicant's appropriateness for certification. A fair and candid report is essential. Therefore, we ask for careful ratings and comments about character and ability. All information submitted will be viewed as confidential and will not be available to the applicant.

YOUR NAME: _____

POSITON/TITLE: _____

BUSINESS ADDRESS: _____

_____

_____

DAYTIME TELEPHONE #: _____

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

Please rate the candidate by circling the most accurate response. Use "Don't Know" ONLY if you have never observed or have absolutely no knowledge of the respective variable.

COUNSELOR SKILL AREAS	**Poor-Excellent**	**Don't Know**
Breadth of knowledge in alcohol and other drug abuse	1 2 3 4 5	
Breadth of knowledge in the twelve core functions	1 2 3 4 5	
Relationship ability	1 2 3 4 5	
Communication skills	1 2 3 4 5	
Sense of responsibility & adherence to state & federal confidentiality regulations	1 2 3 4 5	
Empathy / understanding	1 2 3 4 5	
Openness / genuineness	1 2 3 4 5	
Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
Ability to be objective	1 2 3 4 5	
Flexibility / adaptability	1 2 3 4 5	
Emotional stability	1 2 3 4 5	
Crisis problem solving	1 2 3 4 5	
Counseling abilities & competencies	1 2 3 4 5	

Please provide a written overall assessment of the candidate as a Counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person's professional practice in alcohol and drug abuse counseling.

_____ _____

Signature Date

Professional Recommendation Form

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YOUR NAME: _____

POSITON/TITLE: _____

BUSINESS ADDRESS: _____

_____

_____

DAYTIME TELEPHONE #: _____

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

Please rate the candidate by circling the most accurate response. Use "Don't Know" ONLY if you have never observed or have absolutely no knowledge of the respective variable.

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Breadth of knowledge in alcohol and other drug abuse	1 2 3 4 5	
Breadth of knowledge in the twelve core functions	1 2 3 4 5	
Relationship ability	1 2 3 4 5	
Communication skills	1 2 3 4 5	
Sense of responsibility & adherence to state & federal confidentiality regulations	1 2 3 4 5	
Empathy / understanding	1 2 3 4 5	
Openness / genuineness	1 2 3 4 5	
Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
Ability to be objective	1 2 3 4 5	
Flexibility / adaptability	1 2 3 4 5	
Emotional stability	1 2 3 4 5	
Crisis problem solving	1 2 3 4 5	
Counseling abilities & competencies	1 2 3 4 5	

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_____ _____

Signature Date

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Name of Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that this recommendation will be used in determining my eligibility for certification and is a character reference. Therefore, I agree and understand that I will not be entitled to this information under any circumstance.

_____ _____

Applicant's signature Date

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YOUR NAME: _____

POSITON/TITLE: _____

BUSINESS ADDRESS: _____

_____

_____

DAYTIME TELEPHONE #: _____

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

Please rate the candidate by circling the most accurate response. Use "Don't Know" ONLY if you have never observed or have absolutely no knowledge of the respective variable.

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Breadth of knowledge in alcohol and other drug abuse	1 2 3 4 5	
Breadth of knowledge in the twelve core functions	1 2 3 4 5	
Relationship ability	1 2 3 4 5	
Communication skills	1 2 3 4 5	
Sense of responsibility & adherence to state & federal confidentiality regulations	1 2 3 4 5	
Empathy / understanding	1 2 3 4 5	
Openness / genuineness	1 2 3 4 5	
Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
Ability to be objective	1 2 3 4 5	
Flexibility / adaptability	1 2 3 4 5	
Emotional stability	1 2 3 4 5	
Crisis problem solving	1 2 3 4 5	
Counseling abilities & competencies	1 2 3 4 5	

Please provide a written overall assessment of the candidate as a Counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person's professional practice in alcohol and drug abuse counseling.

_____ _____

Signature Date

TWELVE CORE FUNCTIONS OF THE ALCOHOL AND DRUG ABUSE COUNSELOR AND GLOBAL CRITERIA

All applicants for Chemical Dependency Certification must document 300 hours of supervised practical training in the following Twelve Core Functions, with a minimum of 10 hours in each core function. The twelve core functions represent a specific entity and although they may overlap, depending on the nature of the Counselor's practice the Counselor must be able to demonstrate competency in each core function and global criteria area.

SCREENING: The process by which a client is determined to be appropriate and eligible for admission to a particular program.

Global Criteria

1. Evaluate psychological, social and physiological signs and symptoms of alcohol and other drug use and abuse.
2. Determine the client's appropriateness for admission or referral.
3. Determine the client's eligibility for admission or referral.
4. Identify any coexisting conditions (medical, psychiatric, physical, etc.) that indicate a need for additional professional assessment and/or services.
5. Adhere to applicable laws, regulations and agency policies governing alcohol and other drug abuse services.

This function requires that the counselor consider a variety of factors before deciding whether or not to admit the potential client for treatment. It is imperative that the counselor use appropriate diagnostic criteria to determine whether the applicant's alcohol or other drug use constitutes abuse. All counselors must be able to describe the criteria they use and demonstrate their competence by presenting specific examples of how the use of alcohol and other drugs has become dysfunctional for a particular client.

The determination of a particular client's appropriateness for a program requires the counselor's judgment and skill and is influenced by the program's environment and modality (i.e., inpatient, outpatient, residential, pharmacotherapy, detoxification, or day care). Important factors include the physical condition of the client, outside supports/resources, previous treatment efforts, motivation and the philosophy of the program.

The eligibility criteria are generally determined by the focus, target population and funding requirements of the counselor's program or agency. Many of the criteria are easily ascertained. These may include the client age, gender, place of residence, legal status, veteran status, income level and the referral source. Allusion to following agency policy is a minimally acceptable statement.

If the applicant (client) is found ineligible or inappropriate for the program, the counselor should be able to suggest an alternative.

INTAKE: The administrative and initial assessment procedures for admission to a program.

6. Complete required documents for admission to the program.
7. Complete required documents for program eligibility and appropriateness.
8. Obtain appropriately signed consents when soliciting from or providing information to outside sources to protect client confidentiality and rights.

The intake usually becomes an extension of the screening, when the decision to admit is formally made and documented. Much of the intake process includes the completion of various forms. Typically, the client and counselor fill out an admission or intake sheet, document the initial assessment, complete appropriate releases of information, collect financial data, sign consent for treatment and assign the primary counselor.

ORIENTATION: Describing to the client the following: general nature and goals of the program; rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program; in a non-residential program, the hours during which services are available; treatment costs to be borne by the client, if any, and client's rights.

Global Criteria:

9. Provide an overview to the client by describing program goals and objectives for client care.
10. Provide an overview to the client by describing program rules, and client obligations and rights.
11. Provide an overview to the client of the programs operations.

The orientation may be provided before, during and/or after the client's screening and intake. It can be conducted in an individual, group or family context. Portions of the orientation may include other personnel for certain specific parts of the treatment, such as medication.

ASSESSMENT: The procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of a treatment plan.

Global Criteria:

12. Gather relevant history from client including but not limited to alcohol and other drug abuse using appropriate interview techniques.
13. Identify methods and procedures for obtaining corroborative information from significant secondary sources regarding client's alcohol and other drug abuse and psycho-social history.
14. Identify appropriate assessment tools.
15. Explain to the client the rationale for the use of assessment techniques in order to facilitate understanding.
16. Develop a diagnostic evaluation of the client's substance abuse and any coexisting conditions based on the results of all assessments in order to provide an integrated approach to treatment planning based on the client's strengths, weaknesses, and identified problems and needs.

    Although assessment is a continuing process, it is generally emphasized early in treatment. It usually results from a combination of focused interviews, testing and/or record reviews.

    The counselor evaluates major life areas (i.e., physical, health, vocational development, social adaptation, legal involvement and psychological functioning) and assesses the extent to which alcohol or drug use has interfered with client's functioning in each of these areas. The result of this assessment should suggest the focus for treatment.

TREATMENT PLANNING: Process by which the counselor and the client identify and rank problems needing resolution; establish agreed upon immediate and long term goals and decide upon a treatment process and the resource to be utilized.

Global Criteria:

17. Explain assessment results to the client in an understandable manner.
18. Identify and rank problems based on individual client needs in the written treatment plan.
19. Formulate agreed upon immediate and long-term goals using behavioral terms in the written treatment plan.
20. Identify the treatment methods and resources to be utilized as appropriate for the individual client.

    The treatment contract is based on the assessment and is a product of a negotiation between the client and counselor to assure that the plan is tailored to the individual's needs. The language of the problem, goal and strategy statements should be specific, intelligible to the client and expressed in behavioral terms. The statement of the problem concisely elaborates on a client and counselor to determine progress in treatment. The plan or strategy is a specific activity that links the problem with the goal. It describes the services, who will provide them, where they will be provided and at what frequency.
    Treatment planning is a dynamic process and the contracts must be regularly reviewed and modified as appropriate.

COUNSELING: (Individual, Group and Significant Others.) The utilization of special skills to assist individuals, families, or groups in achieving objectives through exploration of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions and decision making.

Global Criteria:

21. Select the counseling theory(ies) that apply.
22. Apply technique(s) to assist the client, group, and/or family in exploring problems and ramifications.
23. Apply techniques to assist the client, group, and/or family in examining the client's behavior, attitudes, and/or feelings if appropriate in the treatment setting.
24. Individualize counseling in accordance with cultural, gender and life-style differences.
25. Interact with the client in an appropriate therapeutic manner.
26. Elicit solutions and decisions from the client.
27. Implement the treatment plan.

    Counseling is basically a relationship in which the counselor helps the client mobilize resources to resolve his/her problem and/or modify attitudes and values. The counselor must be able to demonstrate a working knowledge of various counseling approaches. These methods may include Reality Therapy, Transactional Analysis, Strategic Family Therapy, Client-Centered Therapy, etc. Further, the counselor must be able to explain the rationale for using a specific skill for the particular client. For example, a behavioral approach might be suggested for clients

who are resistant, manipulative and have difficulty anticipating consequences and regulating impulses. On the other hand, a cognitive approach may be appropriate for a client who is depressed, yet insightful and articulate.

Also, the Counselor should be able to explain his/her rationale for choosing a counseling skill in an individual, group or significant other context. Finally, the counselor should be able to explain why a counseling approach or context changes during treatment.

CASE MANAGEMENT: Activities that bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contracts.

Global Criteria:

28. Coordinate services for client care.
29. Explain the rationale of case management activities to the client.

Case management is the coordination of a multiple services plan. By the time many alcohol and other drug abusers enter treatment they tend to manifest dysfunction in a variety of areas. For example, a heroin addict may have hepatitis, lack job skills and have pending criminal charges. In this case, the counselor might monitor his medical treatment, make a referral to a vocational rehabilitation program and communicate with representatives of the Criminal Justice system.

The client may also be receiving other treatment services, such as family therapy and pharmacotherapy, within the same agency. These activities must be integrated into the treatment plan and communication must be maintained with the appropriate personnel.

CRISIS INTERVENTION: Those services that respond to an alcohol and/or other drug abuser's needs during acute emotional and/or physical distress.

Global Criteria:

30. Recognize the elements of the client's crisis.
31. Implement an immediate course of action appropriate to the crisis.
32. Enhance overall treatment by utilizing crisis events.

A crisis is a decisive, crucial event in the course of treatment that threatens to compromise or destroy the rehabilitation effort. These crises may be directly related to alcohol or drug use (i.e., overdose or relapse) or indirectly related. The latter might include the death of a significant other, separation/divorce, arrest, suicidal gestures, a psychotic episode or outside pressure to terminate treatment. If no specific crisis is presented in the Written Case, rely on and describe a past experience with a client. Describe the overall picture before, during and after the crisis.

It is imperative that the counselor be able to identify the crisis when they surface, attempt to mitigate or resolve the immediate problem and use the negative events to enhance the treatment efforts, if possible.

CLIENT EDUCATION: Provision of information to individuals and groups concerning alcohol and other drug abuse, the implications of, and the available services and resources.

Global Criteria:

33. Present relevant alcohol and other drug use/abuse information to the client through formal and/or informal processes.
34. Present information about available alcohol and other drug services and resources.

Client education is provided in a variety of ways. In certain inpatient and residential programs, for example, a sequence of formal classes may be conducted using a didactic format with reading materials and films. On the other hand, an outpatient counselor may provide relevant information to the client individually and informally. In addition to alcohol and drug information, client education may include a description of self-help groups and other resources that are available to the clients and their families. The applicant must be competent in providing a specific example of the type of education provided to the client and the relevance to the case.

REFERRAL: Identifying the needs of the client that cannot be met by the counselor or agency and assisting the client to utilize the support systems and community resources available.

Global Criteria:

35. Identify need(s) and/or problem(s) that the agency and/or counselor cannot meet.
36. Explain the rationale for the referral to the client.
37. Match client needs and/or problems to appropriate resources.
38. Adhere to applicable laws, regulations and agency policies governing procedures related to the protection of the client's confidentiality.
39. Assist the client in utilizing the support systems and community resources available.

In order to be competent in this function, the counselor must be familiar with community resources, both alcohol and drug and others, and be aware of the limitations of each service and if the limitations could adversely impact the client. In addition, the counselor must be able to demonstrate a working knowledge of the referral process, including the confidentiality requirements and outcomes of the referral.

Referral is obviously closely related to case management when integrated into the initial and ongoing treatment plan. It also includes, however, aftercare or discharge planning referrals that take into account the continuum of care.

REPORTS AND RECORD KEEPING: Charting the results or the assessment and treatment plan, writing reports, progress notes, discharge summaries and other client-related data.

Global Criteria:

40. Prepare reports and relevant records integrating available information to facilitate the continuum of care.
41. Chart pertinent ongoing information pertaining to the client.
42. Utilize relevant information from written documents for client care.

The report and record-keeping function is extremely important. It benefits the counselor by documenting the client's progress in achieving his or her goals. It facilitates adequate communication between co-workers. It assists the counselor's supervision providing timely feedback. It is valuable to other programs that may provide services to the client at a later date. It can enhance the accountability of the program to its licensing/funding sources. Ultimately, if performed properly, it can enhance the client's entire treatment experience. The applicant must prove personal action in regard to the report and record keeping function.

CONSULTATION WITH OTHER PROFESSIONALS IN REGARD TO CLIENT TREATMENT SERVICES: Relating with in-house staff or outside professionals to assure comprehensive, quality care for the client.

Global Criteria:

43. Recognize issues that are beyond the counselor's base of knowledge and/or skills.
44. Consult with appropriate resources to ensure the provision of effective treatment services.
45. Adhere to applicable laws, regulations and agency policies governing the disclosure of client identifying data.
46. Explain the rationale for the consultation to the client, if appropriate.

Consultations are meetings for discussions, decision-making and planning. The most common consultation is the regular in-house staffing in which client cases are reviewed with other members of the treatment team. Consultations also can be conducted in individual sessions with the supervisor, other counselors, psychologists, physicians, probation officers and other service providers connected with the client's case.

Examinee Request for Reasonable Testing Accommodations

Candidates requesting reasonable testing accommodation can complete this form; attach all appropriate documentation from a licensed physician, psychiatrist, or psychologist; and, submit it with the application to: CBADP 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105.

PERSONAL DATA:

Name: _____
First Middle Last Maiden

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Social Security #: _____ Birth date: _____

Examination(s) for which you are requesting testing accommodations: _____

Name and title of Professional(s) whom diagnosed your disability/disabilities: _____

_____ Date(s) Diagnosed: _____

CURRENT DISABILITY (please mark all that apply):
_____Visual Impairment
_____Hearing Impairment
_____Leaning Disability
_____Writing Disability
_____Health Impairment
_____Orthopedic Impairment
_____Mental/Emotional Impairment
_____Other (Please Specify) _____

Please describe the condition that is the basis for your request and the accommodations you wish to be made available:

Prior Testing Accommodations you have been granted for this disability:

Additional Examination Time _____Yes _____ No (If yes, percent additional _____%)
Separate Examination Location _____Yes _____ No (If yes, where: _____)
Assistance _____Yes _____ No (If yes, specify type of assistance _____)
Exam format Accommodations _____Yes _____ No (If yes, please describe _____)
Other (please describe): _____

Accommodations were granted at: _____Elementary School _____High School
_____Professional Program _____College